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FABRAZYME (agalsidase beta)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies: _____

PRIMARY DIAGNOSIS

ICD-10 Code: _____

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Ceterizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO | <input type="checkbox"/> Other: _____ |

PRIMARY MEDICATION ORDER

Dosage

- ☐ 1 mg/kg
☐ Other: _____

Patient Weight:

_____ lbs
_____ kg

Frequency

- ☐ Every 2 weeks

NOTES

ORDERING PROVIDER

| | |
|-------------------------|--------------|
| Provider Name: _____ | NPI: _____ |
| Practice Name: _____ | Phone: _____ |
| Office Contact: _____ | Fax: _____ |
| Practice Address: _____ | |
| City, State, Zip: _____ | |

Provider Signature: _____ Date: _____